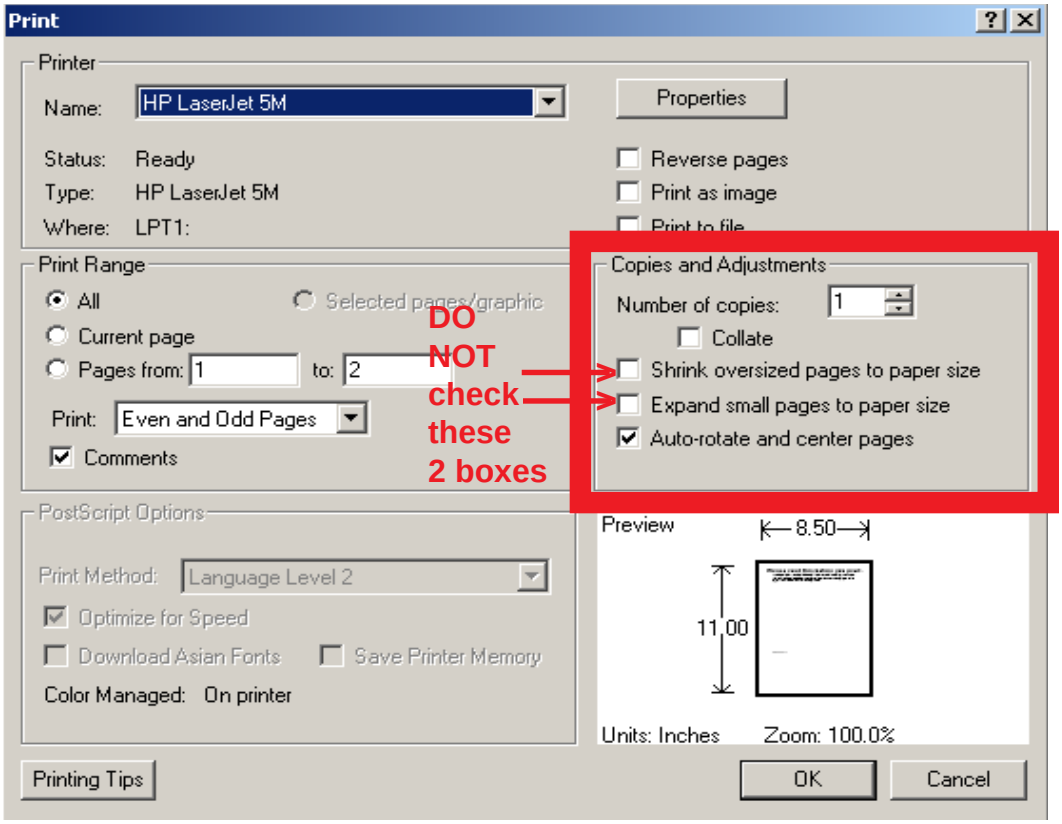
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



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Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Nursing Home Administrator License Application Packet

1. 661-030 .. Contents List/SSN Information/Deposit Slip ..... 1 page
2. 661-022 .. Instructions For Application For Licensure As A Nursing Home Administrator ..... 2 pages
3. 661-020 .. Application For Licensure As A Nursing Home Administrator ..... 4 pages
4. 661-023 .. Verification of Licensure As A Nursing Home Administrator ..... 1 page

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

DOH 661-030 (REV 12/2004)

Nursing Home Administrator

DEPOSIT SLIP

NAME (Please Print)

DATE

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$

☐ **Check**
☐ **Money Order**

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Washington State Department of Health

Instructions for Application for Licensure as a Nursing Home Administrator

These instructions are for Administrator-in-Training and endorsement applicants.

1. Complete the application form. To ensure appropriate review, all information should be typed or printed clearly. A resume **cannot** substitute for completion of the application.

2. List all states in which you now hold or have held a license or credential as a Nursing Home Administrator or other professional license. Also include those states in which you may have applied and a license was never granted. Please include an explanation. The "Verification of Licensure" form must be sent to each state in which you hold or have held a Nursing Home Administrator credential, even if it has now expired. The form must be returned directly to the Board of Nursing Home Administrators (BNHA).

3. If any questions on the Personal Data have a "Yes" response, the explanation and documents required for that answer must be attached.

4. Education. A minimum of a baccalaureate degree is required. Read carefully and complete in full. Request an official copy of your degree transcript. **Transcripts must be received in a sealed envelope directly from the school to the attention of the Board of Nursing Home Administrators, PO Box 47864, Olympia, WA 98504-7864. Transcripts marked "Issued to Student" will not be accepted.**

5. Provide as much information as possible under Professional Experience.

6. Possible contacts for AIDS education and training are: American Red Cross, community colleges, Department of Health HIV/AIDS WEB site http://www.doh.wa.gov/cfh/hiv_aids/prev_edu/training.htm. The requirement is 7 hours of training.

7. Read the Applicant's Attestation and after you have familiarized yourself with RCW 18.130.170 and RCW 18.130.180 of the Uniform Disciplinary Act, sign and date the application form in the spaces provided.

8. Submit the appropriate fee. Make check or money order for application fee payable to the Department of Health and mail with the application form to: Board of Nursing Home Administrators, Post Office Box 1099, Olympia, WA 98507-1099. **Application Fees Are Non-Refundable**.

Note: "Board of Nursing Home Administrators" should be clearly visible on all mail sent to the Department of Health.

Application Fees

Application—Original license	$200.00
Administrator-in-training	$100.00
Application—Endorsement	$295.00

Endorsement Applicants:

If you have obtained a baccalaureate degree, completed an administrator-in-training program, and are currently licensed in another state in good standing, you may qualify for a Washington State Nursing Home Administrator license by endorsement. Complete numbers 1 through 7 on the application form and submit the endorsement application fee of $295.00. If you have successfully completed the National Association of Boards of Examiners for Nursing Home Administrators (NAB) examination, you will not be required to take it again in Washington. A state examination is no longer given in Washington. If you are a nursing home administrator certified by the American College of Health Care Administrators (ACHCA), verification of certification may be submitted in lieu of a college degree transcript.

Notice to Endorsement Applicants: Reference WAC 246-843-230(1)

The board may endorse a nursing home administrator currently licensed in another state if that state requires qualifications substantially equivalent to qualifications required by RCW 18.52.071. Be aware that Washington state requires a 1,500 hour Administrator-in-Training program. A state which requires less may not be considered substantially equivalent.

Administrator-in-training Applicants:

There is an additional fee of $100.00 if an administrator-in-training (AIT) program is required. The Board of Nursing Home Administrators (BNHA) will determine whether an AIT program is required and the length of the program. That determination is based on your experience as outlined in WAC 246-843-090. Please refer to the instructions for Nursing Home Administrator-In-Training Program form for further explanation regarding the AIT program.

Computer based testing for the national NAB examination started January 1, 2000. On-line application for the exam started November 15, 2002. Information about the NAB examination is located on their website at www.nabweb.org. Select exams to access the NHA Information Candidates' Handbook.

Notice To All Applicants: Reference WAC 246-843-130(4)

Within 180 days of initial licensure, nursing home administrators are required to attend a course on laws relating to nursing homes in Washington. Contact the Department of Social and Health Services (DSHS) at (360) 493-2529 to register. For more information, visit the DSHS Aging and Adult Services Administration professional site at http://www.aasa.dshs.wa.gov/Professional/nursetrain.htm.

If you have any questions, you may call (360) 236-4723.

Washington State Department of Health

Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY	
VALIDATION	RECEIVED DATE
LICENSE #	ISSUANCE DATE

LICENSE #

Application For Licensure As A Nursing Home Administrator

☐ **Administrator-in-Training** ☐ **Endorsement (Reciprocity)**

Please Type or Print Clearly—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application. All applications must be accompanied by applicable fee which is nonrefundable. Make remittance payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME	LAST	FIRST	MIDDLE INITIAL

MAILING ADDRESS

CITY	STATE	ZIP	COUNTY

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.)	Social Security Number (**Required** for license under 42 USC 666 and Chapter 26.23 RCW)	BIRTHDATE (MO/DAY/YR)	SEX
( )			☐ Male ☐ Female

Have you ever been known under any other name? ☐ Yes ☐ No

If yes, list

Are you now certified by any well established and generally recognized church or religious denomination which teaches reliance on spiritual means alone for healing? ☐ Yes ☐ No

If yes, explain

While in a degree program, did you complete at least a 1,000 hour training program in a nursing home? ☐ Yes ☐ No

If **yes**, please enclose documentation

If **no**, please submit the AIT fee in addition to your NHA application and fee.

2. Previous Licensure Or Certification

List all states where licenses are or were held.

STATE/JURISDICTION	PROFESSION	CERTIFICATE OR LICENSE		PERMANENT/ TEMPORARY	LICENSE RECEIVED BY		CURRENTLY IN FORCE
		YEAR ISSUED	NUMBER		EXAMINATION	OTHER	
							☐ YES ☐ NO
							☐ YES ☐ NO
							☐ YES ☐ NO
							☐ YES ☐ NO
							☐ YES ☐ NO
							☐ YES ☐ NO
							☐ YES ☐ NO
							☐ YES ☐ NO

3. Personal Data Questions

	YES	NO
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☐
4. Are you currently engaged in the illegal use of controlled substances?	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:		
a. the use or distribution of controlled substances or legend drugs?	☐	☐
b. a charge of a sex offense?	☐	☐
c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceedings to have:		
a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?	☐	☐
b. committed any act involving moral turpitude, dishonesty or corruption?	☐	☐
c. violated any state or federal law or rule regulating the practice of a health care professional?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements.	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority?	☐	☐
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?	☐	☐

4. Education

In the spaces below, provide a chronological listing of your educational preparation and post-graduate training. (attach additional 8 1/2 x 11 sheet if necessary)

SCHOOLS ATTENDED FULL NAME, CITY AND STATE	DEGREE EARNED	ATTENDANCE	
		FROM (MO/YR)	TO (MO/YR)

5. Professional Experience

Start with present position and work back. Include only those positions you have held in the health care and management field, including services in the armed forces. **Attach a detailed description of duties for each position listed on a separate 8 1/2 x 11 sheet.**

1. NAME OF EMPLOYER | TYPE OF BUSINESS

ADDRESS OF EMPLOYER | CITY | STATE | ZIP

POSITION TITLE | NAME OF SUPERVISOR

DATES OF EMPLOYMENT FROM TO | NUMBER OF FULL-TIME EMPLOYEES UNDER YOUR SUPERVISION | NUMBER OF PART-TIME EMPLOYEES UNDER YOUR SUPERVISION

2. NAME OF EMPLOYER | TYPE OF BUSINESS

ADDRESS OF EMPLOYER | CITY | STATE | ZIP

POSITION TITLE | NAME OF SUPERVISOR

DATES OF EMPLOYMENT FROM TO | NUMBER OF FULL-TIME EMPLOYEES UNDER YOUR SUPERVISION | NUMBER OF PART-TIME EMPLOYEES UNDER YOUR SUPERVISION

3. NAME OF EMPLOYER | TYPE OF BUSINESS

ADDRESS OF EMPLOYER | CITY | STATE | ZIP

POSITION TITLE | NAME OF SUPERVISOR

DATES OF EMPLOYMENT FROM TO | NUMBER OF FULL-TIME EMPLOYEES UNDER YOUR SUPERVISION | NUMBER OF PART-TIME EMPLOYEES UNDER YOUR SUPERVISION

4. NAME OF EMPLOYER | TYPE OF BUSINESS

ADDRESS OF EMPLOYER | CITY | STATE | ZIP

POSITION TITLE | NAME OF SUPERVISOR

DATES OF EMPLOYMENT | NUMBER OF FULL-TIME EMPLOYEES UNDER YOUR SUPERVISION | NUMBER OF PART-TIME EMPLOYEES UNDER YOUR SUPERVISION

6. AIDS Eduction and Training Attestation

I certify I have completed the minimum of seven (7) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my registration may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE

7. Applicant's Attestation

I, _____, certify that I am the person described and identified in
Name of Applicant

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

_____ _____

Signature of Applicant Date

Official Use Only

Washington State Records Center

Washington State Department of Health
Board of Nursing Home Administrators
P.O. Box 47864
Olympia, WA 98504-7864
(360) 236-4723
Fax (360) 236-4737

Verification of Licensure
Nursing Home Administrator

TO APPLICANT: Complete top portion in full and forward to each state in which you hold or have held a license/ certificate as a Nursing Home Administrator. Contact each state for information on a fee for this service.

Name (Last, First, Middle Initial)		
Street Address		
City	State	Zip
Daytime Telephone		
I authorize the release of the information requested below to the Washington State Board of Nursing Home Administrators.		
Applicant's Signature	Date	

TO STATE BOARD: The above individual is applying for licensure as a Nursing Home Administrator in Washington State. To assist the Board in their review, please complete the following information and mail to the Washington State Board of Nursing Home Administrators at the address above. Thank you for your cooperation.

License Number:	State:	Date Issued:	Expiration Date:

If this is **not** the state of original license, was license through reciprocity/endorsement? ☐ Yes ☐ No

If yes, from what state?

Status of License: ☐ Active ☐ Inactive ☐ Expired ☐ Other (Specify)

Exam: ☐ NAB ☐ Other (specify)		Exam Date	Exam State
NAB Score: Raw	Scale	Exam Date	Exam State

Was an AIT Program successfully completed? ☐ Yes ☐ No

If yes, please describe:

Has the applicant ever been disciplined by the Board? ☐ Yes ☐ No

If yes, please explain

Is there any investigation or disciplinary action pending? ☐ Yes ☐ No

If yes, please explain

Individual completing form:	Title:	
Signature		Date
Telephone	City	State

This Form May Be Duplicated